Stocks Hall Care Homes Limited

Stocks Hall Nursing Home - Skelmersdale

Inspection report

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Ratings

Overall rating for this service	Good

Is the service safe?	Good
Is the service effective?	Requires Improvement
Is the service caring?	Good
Is the service responsive?	Good
Is the service well-led?	Good

Summary of findings

Overall summary

Stocks Hall Nursing Home is located in a residential area of Skelmersdale. It provides accommodation for up to 60 people who require help with their personal or nursing care needs, including those who are living with Dementia. Facilities are on two floors, served by a passenger lift and staircases. There are a range of amenities within the local community. The home is set in pleasant, well maintained grounds. Patio areas with garden furniture are available on both floors for those wishing to spend some time outdoors. Ample parking spaces are available. Stocks Hall Nursing Home is owned by Stocks Hall Care Homes Limited.

We last inspected this location on 3 February 2015, when we found some improvements were needed in the areas of 'safe' and 'responsive'. The areas of 'effective', 'caring' and 'well led' were rated as 'good'. The overall rating for this location at that time was, 'requires improvement.'

This unannounced inspection was conducted on 3rd February 2016, when the registered manager was on duty. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated regulations about how the service is run.

During our last inspection we found the home did not have effective arrangements in place to ensure that people's medicines were safely managed. However, during this inspection we found the registered manager had made some good improvements, which had resulted in a safer system for managing medicines. However, we established that not all agency nurses, who worked at the home, were familiar with the new electronic system for managing medications. This was discussed with the registered manager at the time of our inspection and we were satisfied that this would be addressed appropriately.

New employees were guided through a detailed induction programme and were supported to gain confidence and the ability to deliver the care people needed. A wide range of mandatory training modules were provided for staff, with additional courses being available in relation to the needs of those who lived at the home. Supervisions and appraisals for staff were conducted. However, these did not appear to be available at structured intervals.

The staff team were confident in reporting any concerns about a person's safety and were competent to deliver the care and support needed by those who lived at Stocks Hall. Accidents and incidents were well recorded and a process was in place for monitoring their occurrence. The care plans we saw were person centred. However, not everyone had been involved in the planning of their care or that of their loved one and some information was not easily accessible by all relevant staff.

Recruitment procedures adopted by the home were robust. This helped to ensure that only suitable people were appointed to work with this vulnerable client group. However, consent had not always been formally obtained prior to care and treatment being delivered and legal authority had always been sought for those

who lacked capacity and whose liberty was being deprived.

The premises were clean and well-maintained throughout. There were no unpleasant smells and clinical waste was being disposed of in the correct manner. This helped to reduce the possibility of cross infection.

Systems and equipment within the home had been serviced in accordance with the manufacturers' recommendations, to ensure they were safe for use. Good infection control practices had been adopted by the home. Risks were well managed and people were handled in a gentle and supportive manner. Emergency plans had been developed, should evacuation of the premises be needed. This helped to protect people from harm.

Staff were kind and caring towards those they supported and people were helped to maintain their independence with their dignity being respected at all times. The staffing levels on the day of our inspection were sufficient to meet the needs of those who lived at the home. We noted that there was involvement of a wide range of community professionals and that people's health care needs were being appropriately met.

We found one breach of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 in relation to need for consent.

You can see what action we told the provider to take at the back of the full version of this report.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good

This service was safe.

At the time of this inspection there were sufficient staff deployed to meet the needs of those who lived at Stocks Hall. Necessary checks had been conducted before people were employed to work at the home. Therefore, recruitment practices were thorough enough to ensure only suitable staff were appointed to work with this vulnerable client group.

Robust safeguarding protocols were in place and staff were confident in responding appropriately to any concerns or allegations of abuse. People who lived at the home were protected by the emergency plans implemented at Stocks Hall and medications were, in general being well managed.

The premises were safe and were maintained to a good standard. Assessments were conducted to identify areas of risk. Infection control protocols were being followed, so that a safe environment was provided for those who lived at Stocks Hall.

Is the service effective?

Requires Improvement

This service was not consistently effective.

The staff team were well trained and knowledgeable. They completed an induction programme when they started to work at the home, followed by a range of mandatory training modules. However, the system for supervision and appraisal of staff could have been more structured.

We established that formal consent had not always been obtained prior to care and treatment being delivered. Systems were in place for the management of DoLS applications.

The menu offered people a choice of meals and their nutritional requirements were being met. Those who needed assistance with eating and drinking were provided with help in a discreet manner.

The environment was well designed in accordance with the needs of those who lived at the home.

Is the service caring?

Good

This service was caring.

Staff interacted well with those who lived at the home. People were provided with the same opportunities, irrespective of age or disability. Their privacy and dignity was consistently promoted.

People were supported to access advocacy services, should they wish to do so. An advocate is an independent person, who will act on behalf of those needing support to make decisions.

People were treated in a respectful way. They were supported to remain as independent as possible and to maintain a good quality of life. Staff communicated well with those they supported and were mindful of their needs.

Is the service responsive?

Good

This service was responsive.

An assessment of needs was done before a placement was arranged. Plans of care were person centred and reflected people's needs or how these needs were to be best met.

People were transferred in a safe way and therefore were protected from injury.

Staff anticipated people's needs well. The management of risks helped to ensure that strategies were implemented and followed, in order to protect people from harm.

People we spoke with told us they would know how to make a complaint should they need to do so and staff were confident in knowing how to deal with any concerns raised.

Is the service well-led?

Good

This service was well-led.

People who lived at the home were fully aware of the lines of accountability within Stocks Hall. Staff spoken with felt well supported by the management team and were very complimentary about the way in which the home was being run by the long standing manager.

There were systems in place for assessing and monitoring the quality of service provided. People who lived at the home were involved in the day to day operation.

The home worked in partnership with other agencies, such as a wide range of external professionals, who were involved in the care and treatment of the people who lived at Stocks Hall.

Stocks Hall Nursing Home - Skelmersdale

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider was meeting the legal requirements and regulations associated with the Health and Social Care Act 2008. We also looked at the overall quality of the service and provided a rating for the service under the Care Act 2014.

This unannounced inspection was carried out on 3 February 2016 by four Adult Social Care inspectors from the Care Quality Commission. At the time of this inspection there were 60 people who lived at Stocks Hall. A large percentage of them were unable to discuss what life was like at the home. However, we were able to ask seven of them and six of their relatives for their views about the services and facilities provided. We received positive comments from everyone. We also spoke with thirteen staff members and the registered manager of the home. We used the Short Observational Framework for Inspection (SOFI) on two occasions during our visit to this location. SOFI is a specific way of observing care to help us understand the experience of people who could not talk with us.

We toured the premises, viewing a selection of private accommodation and all communal areas. We observed the day-to-day activity within the home and we also looked at a wide range of records, including the files of eight people who lived at Stocks Hall, whose care we 'pathway tracked'. This enabled us to determine if people received the care and support they needed and if any risks to people's health and wellbeing were being appropriately managed. We also examined the personnel records of four staff members, as well as a variety of policies and procedures, training records, medication records and quality monitoring systems.

The registered manager had completed and submitted a Provider Information Return (PIR), within the timeframe requested. This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make.

Prior to this inspection we looked at all the information we held about this service. We reviewed notifications of incidents that the provider had sent us since our last inspection and we asked local commissioners for their views about the service provided. We also requested feedback from 10 external professionals, such as GPs, community nurses, mental health teams and a practice manager. We received four responses. Their comments are included in the body of this report.

Good

Is the service safe?

Our findings

When asked if people felt safe at Stocks Hall, responses included, "I feel safe. If you buzz for them (the staff) they come to you. There is someone here all night."; "I get very well looked after. Everyone is so good and I feel very safe staying here" and "I get up and go to bed when I want to. You just tell one of the nurses and they help you."

One family member said, "I was really impressed when we first came in here and I am even more impressed now. It's great." Another commented, "I can sometimes come at lunchtime and she is not up. But it doesn't happen too often."

During our last inspection we found the home did not have effective arrangements in place to ensure that people's medicines were safely managed. However, during this inspection we found the registered manager had made some good improvements, which had resulted in a safer system being implemented for the management of medications.

We found the general storage of medicines was satisfactory including that of refrigerated lines and controlled drugs. Medication and store rooms we checked were locked, which helped to ensure the safety of people who used the services. However, the medicines room on the ground floor was found to be cluttered and unclean in some areas. This was discussed with the registered manager of the home at the time of our inspection, who assured us that this would be addressed without delay.

The home had recently introduced a new electronic system for the management of medicines. This covered the whole process from booking in medication stocks, when they arrived from the pharmacy, recording when medicines had been administered and recording medicines which had been returned to the pharmacy or destroyed. Staff spoken with, were in general quite positive about the new system. The general consensus was that the system had a number of benefits, which would increase in time, as staff became more efficient at using the system.

Benefits of the new system included various safeguards, such as automatic warnings if medicines were attempted to be administered at the wrong time or too close together. Those responsible for medications would also be alerted if they attempted to administer medicines, which should not be given together or if they attempted to administer a medicine to someone who was recorded as having an allergy to it. The system also alerted staff if any person's stock of medicines was running low.

Useful management reports were available at any time. For example, the registered manager was able to print off a management report, which would identify if any person's medication had been missed. The system also provided an ongoing stock count, which meant medicines could be easily audited at any time. This helped the registered manager identify any errors and address them quickly.

Paper records were maintained for topical applications, such as cream and ointments. These records included a body map and clear information as to where on the body, a person's treatment should be

applied.

Staff used electronic handsets to record the majority of medication. The handsets included information about the support each person needed and particular preferences they had, such as 'likes to take with a drink. Give plenty of time to swallow.'

Some people were prescribed medicines on an 'as required' basis. In these circumstances, there should be clear recorded information about when the medicines should be administered. This information is often referred to as PRN protocols. We noted that for some people, PRN protocols had not been completed. These included people prescribed medication for agitation or anxiety. The plan of care for one person, who needed PRN medication for aggression and agitation, did not provide staff with clear guidance about the protocols they needed to follow in order to administer such medication safety. We discussed this with the registered manager who advised us that work to complete the PRN protocols was underway and that they would be completed as a matter of priority.

The staff we spoke with told us it had taken a little time to get used to the system but they were now feeling confident. However, we were told that on one recent occasion, an agency nurse had worked at the home and there had been no opportunity to train them in the system as part of their induction. This had resulted in another member of staff having to stay on after their shift had finished to complete an additional medicines round. This was discussed with the registered manager at the time of our inspection and we were satisfied that this would be addressed appropriately.

Detailed policies were in place in relation to safeguarding adults and whistleblowing procedures. Staff we spoke with had all done training in relation to safeguarding adults and were aware of their responsibilities to protect people from abuse. They told us they would escalate matters to the safeguarding team or CQC if they believed matters were not being dealt with. We saw a poster on a noticeboard describing the step by step process for safeguarding vulnerable people.

Staff we spoke with understood how to whistle blow and said they would approach the registered manager in the first instance and head office, if they felt action was not being taken. Comments from staff around protecting people included: "If I had any problems or concerns I would be happy to talk to one of the seniors or the manager and I know they would listen"; "That's one thing we do get. Plenty of training. All the staff do safeguarding training during their induction" and "I know about whistleblowing and have used it in the past, not here, but if I needed to I would use it again without hesitation."

One community professional wrote on their feedback, 'In respect of Safeguarding Enquires, all the staff have been very co-operative with the enquiry and they have not hesitated to suspend any staff member or nurse where it has been justified. They have followed any recommendations made and put protection plans into place to safeguard the vulnerable adult. Any information I have needed for the enquiry has been given and any documentation to be viewed has also been available. I don't actually have any complaints about Stocks Hall or the service in my dealings with them.'

Records showed that any accidents and incidents were well documented and audits were conducted, so that the managers of the home were able to monitor their frequency and determine if any patterns emerged. Risk assessments were in place in areas such as falling and nutrition.

Both the internal and external environments were well maintained and people who used the service moved around freely and safely. A range of environmental risk assessments had been conducted. We saw people who required to be transferred by hoists were assisted by staff, who used the correct moving and handling

techniques, in a competent, confident and patient manner. A lot of reassurance was provided to those being assisted, which was good practice.

A risk assessment and detailed policy was in place in relation to fire prevention and a fire alarm zone plan was prominently visible within the reception area of the home. Seven members of staff had been trained as fire marshals. This helped to ensure the staff team were kept up to date with fire procedures and associated practices. A business continuity management plan outlined action that needed to be taken in the event of power failure, loss of utilities and severe weather conditions.

Personal Emergency Evacuation Plans (PEEPS) for individual people were in place on the computerised system. However, we suggested that these records be retained in a central location, for easy access to the emergency services, with an associated traffic light system for easy recognition. This would help people to be moved from the building in the safest and most appropriate way, if the need arose. Fire drills were periodically conducted, so that the staff team maintained good fire practices. Staff spoken with were aware of people's requirements in case of emergency evacuation procedures.

We looked at the personnel records of four members of staff. We found recruitment practices adopted by the home were thorough. All relevant information had been gathered before people started to work at the home, which included application forms, health questionnaires, police checks and written references. This helped to ensure only suitable people were appointed to work at the home. Evidence was available to demonstrate that disciplinary action was taken, in accordance with the policies and procedures of the home in response to staff misconduct. This helped to protect those who lived at the home from harm.

People who lived at the home, their relatives and staff members felt the staffing levels were generally adequate. During our inspection we noted a good amount of staff to be on duty and we did not recognise any concerns about the staffing levels in the home, at that time. The registered manager gave us some good examples of situations where circumstances had dictated a need for flexibility in staffing levels. For example, on the day of our visit one person was uncooperative with the one to one member of staff allocated to them for part of the day. Therefore, alternative staffing arrangements were made to facilitate the needs of this individual. One member of staff we spoke with told us, "We might be short staffed sometimes, but it is because someone has gone off sick or someone needs a one to one. We would have to crack on. They won't bring in extra staff."

We found that people's needs were being met by the staff team and those who lived at the home looked well presented. Staff we spoke with told us that agency nursing staff were used regularly at night-time, but that the companies own agency staff were used, who knew the policies and procedures of the organisation. This helped to ensure people received a consistent approach to care and support. Those who worked at Stocks Hall on a permanent basis told us that the agency staff used were confident and professional and that they received an induction checklist to guide them in their duties.

Systems and equipment within the home had generally been serviced in accordance with the manufacturers' recommendations, to ensure they were safe for use. However, the valid service certificates for the fire alarm system and the emergency lights could not be located on the day of our inspection. The registered manager subsequently forwarded these to us. The premises were clean and well-maintained throughout. There were no unpleasant smells and clinical waste was being disposed of in the correct manner. This helped to reduce the possibility of cross infection.

We looked at the toilet and bathroom areas and found them to be clean. We saw hand cleanser, liquid soap, paper towels and pedal bins. Hand washing instructions were displayed on the wall which provided a useful

reminder of the required hand washing procedure. The recent food hygiene inspection conducted by the Environmental Health Officer showed a rating of 5, which is the highest grade available. We observed that people who entered the kitchen put on white gowns to reduce the possibility of cross infection.

Staff wore their own clothes for work, which helped them to integrate in to the daily activities of each unit. However, we noted at lunch time that some staff were wearing protective clothing, such as aprons, but others were not. We discussed this with the registered manager at the time of our inspection, who told us that protective clothing was not routinely worn by staff at meal times because Stocks Hall was the home of those who lived there and to wear such clothing would detract from this philosophy. The registered manager also added that relatives were not requested to wear protective clothing either when assisting with meals for their loved ones. However, we saw staff washing their hands before serving food, although one staff member did push a person in a bucket chair into the dining room and began helping him to eat without putting on gloves or washing their hands.

Requires Improvement

Is the service effective?

Our findings

People who lived at the home and who we spoke with during our inspection told us, "We get lovely food all the time. We always get a choice and we are asked what we would like"; "The carers are all good and if I needed anything, like a doctor, I know they would ring one for me."; "The food is quite good. You get two choices or you can order a salad or a sandwich" and "The food is beautiful. Absolutely perfect."

One family member told us, "We don't live close and we need to travel, but we have no worries. We get regular phone calls from the staff."

We saw that consent forms were present in the care files we looked at, but these had not been signed by the person who used the service or any representative. The consent forms we saw only covered areas related to the taking of photographs and did not incorporate the administration of medication or sharing of information, which is considered to be good practice. However, we heard staff asking people for their consent before providing support on several occasions.

There appeared to be some confusion related to agreement and consent. The provider might like to note that families may, and should, be consulted about the proposed care and support, and their views taken into account. However, they do not have automatic legal authority to provide permission for the proposed care or treatment. Only people who have a Lasting Power of Attorney (LPA) or, have been appointed by the Court of Protection as a deputy, have legal authority to give consent on behalf of a person who lacks capacity to do so.

Evidence was not always available to show that mental capacity assessments were consistently conducted. Mental capacity assessments are a necessity when caring for people living with dementia or any form of cognitive deficit to help support them make their own choices and decisions. This also promotes their individual independence and gives them more control over their life choices. We would also expect the provider to complete a mental capacity assessment before a DoLS application is submitted to the local authority.

We found that evidence was not available to demonstrate that consent had always been obtained from the relevant person prior to care and treatment being provided, in accordance with legal requirements. This was in breach of regulation 11(1)(2)(3) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The Care Quality Commission (CQC) is required by law to monitor the operation of Deprivation of Liberty Safeguards (DoLS). The Mental Capacity Act 2005 (MCA) is legislation designed to protect people who are unable to make decisions for themselves and to ensure that any decisions are made in people's best interests. DoLS are part of this legislation, which ensure that where someone may be deprived of their liberty, the least restrictive option is taken.

Records showed that DoLS applications had been made, as needed and a log was kept for easy reference.

This enabled the registered manager to keep track of how many applications had been made and how many had been approved. Dates were also included on the register, so that the manager was aware of when renewals were due. However, we were made aware that one person's renewal had accidently lapsed and therefore the individual was, for a short period being unlawfully deprived of their liberty. This was discussed with the registered manager, who told us that she had addressed the situation immediately it had been brought to her attention and had therefore requested an extension and submitted an urgent authorisation, as well as a standard application.

The manager told us DoLS applications had been sent to the local authority, but not all had been assessed because of a current backlog. We saw that necessary assessments, including best interest decision making had been completed. Records showed staff had completed training in the MCA and DoLS. During our inspection, we noted that senior staff had a good grasp of the DoLS procedure, but others were not so clear about the process and legal requirements. However, one staff member did tell us, "All senior staff are responsible for applying for DoLS".

Three plans of care we examined included, 'Do Not Attempt Resuscitation (DNAR)' orders. Evidence was available to show that the particular individuals and their families had been involved in making this decision. One person was being supported by an independent advocate to make decisions in relation to a DNAR order. People's end of life wishes were recorded and families had also been involved in discussions with health care professionals before any decisions were made.

At the time of our inspection we noted six people, who lived with dementia were assessed as needing 1:1 support. Records showed that, where necessary meetings had been held to ensure that decisions had been made in the best interests of the individual, by a multi-disciplinary team approach.

We saw some good examples of involvement from community professionals. This helped to ensure people's health care needs were being consistently met. There were processes in place to assess the risks to people with poor nutrition and hydration. The service used an assessment tool, which looked at all areas of nutritional needs. We viewed the care plan of one person who had some additional needs in this area because he had diabetes. We saw there was some advice for staff in the care plan about how to support this person to maintain safe nutritional levels. There was also a good level of information about this person's dietary preferences and food dislikes.

Records showed that any new employees were provided with a range of information, which helped them to do the job for which they had been employed. Staff described their induction programme to us. They told us that this was very detailed and covered a six month period, which was monitored by a checklist of their achievements. It included mandatory training in safeguarding adults, moving and handling, fire awareness, food hygiene and health and safety. Staff told us that they were able to shadow experienced staff members for two weeks and said a good amount of support was provided. Records seen confirmed this information as being accurate.

It was pleasing to see that a recorded induction was provided to agency staff before their initial shift at the home, which covered areas, such as an overview of the home, a tour of the premises, introductions, fire safety, their role, policies and procedures, the employee handbook, confidentiality, accident reporting, the telephone system and health and safety.

Records we saw showed that staff supervisions were held periodically and appraisals were conducted. This enabled employees to meet with their line managers to discuss their work performance and to identify any additional training areas required. Monthly reflection sheets were completed by each member of staff,

which highlighted what had gone well and what could have been gone better. This helped staff members to evaluate their work performance and to identify any areas of best practice. However, although nursing staff told us they received supervision once a month with their line manager and were appraised every six months, other staff members felt their supervision sessions were somewhat erratic. Comments made by staff, in relation to personal development varied and included, "I think if there is one thing we need it's more supervisions. I can't remember my last one"; "If you want to attend external courses they (the company) will fund you" and "The lack of an appraisal means I don't know what's good or what I need to improve."

The staff notice board clearly displayed a wide range of planned mandatory training for the staff team, including customer care, infection control, fire awareness, safeguarding adults, food hygiene, health and safety and moving and handling. We were told that training for staff was provided in different formats, such as classroom teaching, practical skills, knowledge checks and e-learning modules. We were also told that there were five laptops available for staff to use, as well as a computer, based in the staff room. This helped to ensure staff had sufficient resources to complete the required learning programmes. Staff told us they received regular training, which included updates on medicines management, dementia awareness, oral hygiene, challenging behaviour management and first aid. One member of staff told us, "I have just done some training and I have got some more coming up next week."

Staff members we spoke with confirmed there was a training programme for the staff team, which covered a wide range of mandatory learning modules. This information was supported by the staff records and training certificates we saw. Which included areas, such as safeguarding people, infection control, moving and handling, fire awareness, health and safety, dementia awareness and first aid. Staff we spoke with were very knowledgeable about people's care needs and how these were to be best met, which was pleasing to note.

We looked at the kitchen area and found it was clean and hygienic. A no entry sign was on the kitchen door and protective clothing was available for people to use before entering the kitchen. Fridge and freezer temperatures had been recorded appropriately on a daily basis. We looked at random food items and found they were all within the recommended use by date. Hand washing facilities were seen and the kitchen staff wore protective clothing which minimised the risk of any cross contamination. All cooking utensils had been cleaned appropriately and we saw different coloured chopping boards were used for various types of food. The menu was designed over a four week period. There were a variety of choices available and overall the menu was well balanced and catered for people who required a specialised dietary intake due to a medical condition, cultural needs or just individual preferences.

We saw written menus displayed on the wall of the dining room on the dementia care unit. We were told picture menus were not used for those people who lived with dementia. However, we saw people being shown two meals to help them choose their preferred option. We discussed this with the registered manager at the time of our inspection, who explained that those who lived with dementia were unable to remember the selection they had made and therefore it was better to let people select their chosen menu at the time of the meal. We noted that one person found it difficult to settle and sit down for a meal, so they were given a bowl with finger food to enable them to walk around whilst eating. This helped to ensure this person received adequate nutrition.

The menu of the day on the ground floor was hand written on a blackboard within the dining room. However, although two options of meals were evident this was barely legible and people would have difficulty in deciphering what choices were available. However, it was evident that people were offered choices and that alternatives to the menu were available.

We observed lunch being served on both floors of the home. Meals were served in the dining rooms or in the lounge areas. Dining tables were attractively set. We observed staff helping people who needed assistance, in a gentle and supportive manner. One person was receiving end of life care and was being assisted with nourishing drinks during the day. People who lived at the home told us they enjoyed the food provided. The meals served at lunch time were attractively presented and in ample portions.

We toured the premises and found all areas of the home to be clean, warm and comfortable. We saw one bathroom on the ground floor which has been refurbished to a very high standard and included a Jacuzzi bath with mood lights. Level access was available at the front of the home, which would benefit any people who were wheel-chair users and specialised equipment had been provided for people, as was needed, which helped them to experience maximum comfort, safety and helped in the prevention of health care risks. The environmental layout of the home was suitable for the needs of those who lived at Stocks Hall. There were a variety of sitting rooms, where people could join in activities or they could just relax in the quieter lounges, if they preferred. People could also use their own rooms, as they wished for privacy and for seeing their visitors. The dining rooms were well designed, providing pleasant surroundings for people to enjoy the dining experience.

One community professional who provided us with some very positive feedback, which is recorded within other sections of this report, also felt that, 'The level of need of those service users on the dementia care unit appear to be too great for what I consider to be a small environment, even if all the service users were on a one to one. The complex needs of those vulnerable adults really requires more space to give them the opportunities their disabilities require. For example, those that are constantly mobile, resistive to people in their personal space, disinhibited and prone to hitting out I feel need more floor space to help prevent altercations between the service users, ultimately offering improved protection plans and to reduce safeguarding incidents.' However, on the day of our inspection we found the environment on the dementia unit, safe, stimulating and pleasant smelling. Great effort had been put in to support people who were living with dementia. Appropriate signage on bathroom and toilet doors helped people become better orientated within the environment. All staff were dressed in their own clothes for an informal atmosphere and approach. Corridors were well lit, wide and had hand rails with appropriately placed rummage items for stimulation. Plenty of tactile items and play boards were readily available for those who lived with dementia. People who lived on this unit had brightly painted "front" doors, with a brass knocker and letter box, although it was noted that bedroom doors of the same colour were often clustered together. This did not consistently assist with people's maximum potential for orientation. However, each bedroom door was personalised with a photograph of the person who lived in that room and their individual key worker was identified. A key worker is an allocated member of staff, who has overall responsibility for ensuring those in their care receive the support they need and prefer. Bathroom and toilet doors displayed a picture sign on them for familiarity and we noted that toilet facilities had different coloured wall coverings to toilet seats, for easy recognition.

Good

Is the service caring?

Our findings

People who lived in the home told us, "The carers are good. Some are more helpful than others. You have a good laugh with most of them. I've never heard them speak sharply"; "When they (the staff) get a chance the carers sit down and talk to us, but they do get busy. They are very kind with us" and "The carers knock before they come in my room and I think that's nice."

One relative we spoke with told us, "The carers are all spot on. I could not fault the care they provide" and another commented, "It is brilliant. They cannot do enough for you. [Name removed] came in for emergency respite and they [the home] were fantastic. They took her in and made sure they knew everything about her. She's had to stay longer than we thought, but she has settled really well. I find all the staff really good. You can talk to them about anything, any questions or worries they will sort it. We are really, really pleased with everything." Another commented, "[Name removed] was at another home before here. We have found such a difference. An immense improvement. We are so happy he has moved here. It feels much more caring. I can't speak highly enough of them [the staff]. We are kept up to date with everything that happens."

We heard one member of staff, who was working on the dementia care unit, discussing with the unit manager how people's mealtime experiences could be enhanced. We established that the staff member was a 'dignity champion' and referred to this when advising the unit manager that he had some ideas for improvement. The staff member clearly took his role as 'dignity champion' seriously. This was pleasing to see.

Notices within the home showed that a monthly family support group had been introduced, where families could meet up and discuss any relevant topics, such as ideas for activities or fund raising events over a cup of tea or coffee. One care worker when talking about her role said, "I hope we make them [residents] feel good."

A wishing tree was prominently displayed within the reception area of the home, so that anyone could make a wish and place it on the tree.

Staff spoken with talked about people in a respectful manner and were seen approaching people with kindness and patience. The privacy and dignity of people was consistently maintained. We observed consistently good humoured interaction between staff and those who lived at the home. People seemed to enjoy this joyful 'banter'. Staff were seen to be very patient with people's choices of food over lunch and tried hard to encourage people to eat. We saw one person being supported on a 1:1 basis by a carer. This individual was displaying both verbal and physical aggression, but the care worker remained calm, kind and reassuring throughout. Visitors we spoke with commented about how caring and homely Stocks Hall was.

Relatives we spoke with told us they were happy with the attitude of all staff members and they had observed staff chatting regularly with people who lived at the home. We observed relatives and friends visiting people who lived at the home throughout the day without any restrictions. Policies and procedures were in place in relation to equality and diversity. This helped to ensure people who lived at the home were

provided with the same opportunities.

Relatives we spoke with also confirmed they were kept well informed about any changes in their loved ones' circumstances. We observed personal care to be delivered by staff in a caring and dignified manner. We saw one member of staff adjusting a person's clothing to protect their dignity. This was done in a discreet and inconspicuous manner. We saw that people's rooms were bright and airy and were personalised with pictures, photographs, blankets, plants and ornaments. The main lounge was warm, airy and well lit with a television on at low volume and people were sitting in comfortable chairs, positioned at angles conducive to conversation, which was pleasing to see.

We noted information leaflets were available for people in the reception area of the home. These included the dignity in care charter, a pictorial staff rota, and information about the activities programme within the home and details telling people how to contact the local advocacy service, should they wish to do so. This is an independent organisation, which provides people to act on a person's behalf, should they wish to be supported through decision making processes. We saw staff members providing people with good explanations about daily activities before any interaction was commenced.

Records showed that the home had been accredited with the six steps to success end of life care training programme. We received feedback from one person involved in providing this training, who commented, 'The staff are very well led by the manager and her deputy. Teaching sessions within the home are always very well attended. Staff are encouraged to develop skills In all aspects of care. The staff are always very welcoming and demonstrate a keen interest in learning. The managers allow time for staff to attend training. The home is particularly involved in 'Dying Matters', by holding annual events which involve residents, families, staff, and outside professionals. I have always been very impressed with the commitment shown to residents and families'. One member of staff told us, "I let them (the residents) do what they can for themselves and then I help them finish it off." Another commented, "Their (the residents') needs are so different and so personal."

Accident records were maintained in line with data protection. This meant that people's personal details were kept in a confidential manner.

Good

Is the service responsive?

Our findings

People we spoke with told us they felt able to raise issues of concern with the manager and felt that any issues would be dealt with. They said, "I would just see one of the carers if I had a problem. I talk to them every day" and "I have never had to complain about anything, because I am happy with everything the carers do for me."

A relative we spoke with on the day of our inspection told us, "When we arrived today we spoke with the manager about [name removed] care plan. We do get asked what we think."

The care records were uploaded on to a computerised system. We pathway tracked the care of eight people who lived at Stocks Hall. We found that holistic assessments of needs had been conducted before a placement at the home had been arranged. This helped to ensure that the staff team were confident in providing the care and treatment required by each individual, who went to live at the home. Records we saw indicated that people and their families were involved in the pre-admission assessments, which included people's life history, personal choices, preferences, risks and support needs. The home also liaised with the person's previous location, such as hospital or other care facility, to ensure they had comprehensive information about the person moving in to Stocks Hall. Staff told us that on admission, equipment to mitigate risk, such as sensor mats were ordered and a need for 1:1 support was identified, where necessary.

The care plans we saw were person centred and provided good guidance for staff about individual needs and how these assessed needs were to be best met. People's likes, dislikes and preferences had been recorded well. The records of one person showed that he preferred to get up later than most people and we saw staff assisting him to get up at 11am. However, it was not always recorded if people who lived at the home or their families had been involved in the planning of care and support. People's care needs and areas of risk were reviewed each month and any changes in need were recorded well. We discussed this with the registered manager at the time of our inspection and we were satisfied that a record of people's involvement would be introduced for everyone who lived at the home.

Whilst nursing staff were competent in using the computerised system, some care staff told us they had poor computer literacy and had to ask nursing staff to access information they required to support people. We were concerned whether agency staff would be able to access the information easily, as there were no care plan summaries available for easy reference. Some information was retained in a hard copy format, such as DNAR orders, DoLS authorisations, medical investigations, reports from health care professionals and family details. We found the electronic system difficult to navigate as care plans were not linked to ongoing reviews and the most current information was not easy to locate. We discussed this with the registered manager and advised the importance of ensuring that all significant information is easily accessible by all relevant staff members, so that they can provide the planned care and support needed by each individual.

We observed staff members responding to people's questions in a friendly and well-mannered way. Care records showed that many families visited regularly and were kept well informed about health care matters, which included meetings held every six months, involving social workers, to review progress and the

appropriateness of the care being delivered. People's allergies had been recorded and hospital passport had been developed. This helped to ensure that relevant information was available for other health care professionals, should anyone need to be transferred to hospital.

We saw a variety of charts, which recorded and monitored a range of areas of healthcare, such as nutrition, pressure and weights. However, we noted that the charts for one person, who was receiving end of life care, had some observations missing and did not fully reflect what was written in this individual's plan of care. The daily notes provided staff with good information about the events of each shift and any changes, which had been made. Care records indicated that community healthcare professionals visited the home regularly, which helped to ensure that people's healthcare needs were being appropriately met. One person told us an occupational therapist had provided her with a sling, which she could sit on all day, as she could only move with the aid of a hoist.

We looked at the care of one person who had been admitted to the home several days previously. The care plan described a number of complex care needs. However, guidance was in place for staff about how to support this individual and those spoken with demonstrated a good understanding of the person's needs and the care and treatment they required.

We visited one person in their bedroom, who needed a high level of nursing care intervention. We noted a range of specialised equipment had been provided and care charts demonstrated that good pressure relief was being delivered frequently. We overheard one member of staff following instructions, which had been recorded by a community health care professional, which was pleasing to hear. Staff spoken with had a good understanding and knowledge of people's individual care needs. This helped to ensure that appropriate care and support was consistently provided. We saw that people had been provided with equipment to mitigate risks, such as a falls and tissue breakdown.

Risk assessments had been conducted for pressure areas, falls, and mobility. Malnutrition Universal Screening Tests (MUST) were also seen. Together these records helped to promote people's health, welfare and safety. We were told that plans of care were reviewed by the nursing staff on each unit every month. Of the eight care records we looked at, seven had been reviewed and updated each month, with changes in needs being recorded, so that staff were provided with up to date information about those in their care. However, the care plan for one person, who displayed behaviour that challenged the service both verbally and physically, had not been reviewed for two months. This was discussed with staff members and the registered manager at the time of our inspection, who investigated the reason for this without delay and addressed the omission immediately.

Staff told us that 'handovers' between shifts made them aware of any moving and handling issues or of people who were unwell and in need of extra care. People's rooms were checked at the start of each shift. A key worker monitored changes and reported back immediately to the senior person on duty. People had easy access to the external garden area via an open patio door, which led to the secure back garden.

We saw some good examples of staff members offering people choices and anticipating people's needs well. We saw a lot of good practices, which highlighted the caring attitudes of staff. All staff appeared to be alert to the needs of those who lived at Stocks Hall. People looked well-presented and appropriately dressed.

We established that two activity co-ordinators were employed at the home, who were responsible for planning, implementing and evaluating activities within the home and also within the wider community.

Stocks Hall Care Home group owned a mini bus, which was available to those at Stocks Hall, Skelmersdale one and a half days per week, so that those who lived at the home could experience some community activities, if they wished to do so. Photographs of outings, events and celebrations were displayed within the home and we noted that a number of trips out were planned to take place during the warmer weather, including a trip to the Lowry Centre, Liverpool Cathedral, Rufford Marina and a local garden centre.

Advertised forthcoming internal events included, a themed lunch to celebrate the Chinese New Year and pancake tasting on Shrove Tuesday. A special meal for Valentine's Day for those who lived at the home and their guests had also been arranged, which offered a special menu of 'Cupid's Bowl', 'Honeymoon Chicken' and 'Lovers' delight'. A special raffle had also been arranged to celebrate this occasion.

Religious services were held each month by the ministers of local churches. This helped people to continue to follow their religious faiths whilst living at the home.

We noted a sweet vending machine was situated within the reception area of the home and an extensive range of second hand books were on sale, with all proceeds going to the residents' fund for future events and activities.

Memory boxes with various personal and significant items were seen outside people's bedroom doors. This helped to promote individuality and establish ownership. The bedrooms we viewed had a variety of personal possessions displayed.

There were two activity coordinators employed at Stocks Hall. At the time of our inspection one of them was on duty. We spoke with this member of staff, who was very enthusiastic and eager to provide a range of leisure activities suitable for those who lived at the home. She as was very knowledgeable about the type of activities people might be stimulated by. She assessed individual needs and grouped people together for similar activities. We noticed that there were plenty of activities being provided on the day of our inspection and the dementia care unit was a hive of activity, with small group and individual activities in progress. We saw the activity co-ordinator leading an activity of tasting drinks which might stimulate memories. People could go out on half day trips in a mini bus to a public house, cafes, museums, shopping and a local park to feed the ducks. Sensory activities included perfume smelling, hand massage, herbal teas and aromatherapy.

A complaints policy was prominently displayed within the home. This informed people of the procedure to follow, should they wish to make a complaint and advised them of the various stages and timescales to expect. A system was in place for the recording and monitoring of complaints received by the home.

A community professional wrote on their feedback, 'With regards to residential care I have found Stocks Hall to be very caring, person centred and all documentation up to date. They have followed any care plan and nothing has been too much trouble for them. They have accommodated and met all service users' needs that I have dealt with and I don't recall having any complaints about them.'

Good

Is the service well-led?

Our findings

Comments received from people who lived at the home included: "I know the manager, I see her often. If anything goes wrong I know if I tell her it will be fixed" and "I would recommend the home. You get looked after here."

The registered manager of the home had been in post for many years. Everyone we spoke with were aware of the lines of accountability within the home and could identify the manager by name and by sight. They told us she goes to speak with people occasionally, but as there were also unit managers employed at the home, there was always someone to raise any concerns with. Staff spoke positively about the management team. Their comments included: "They (the managers) are very nice and easy to talk to"; "I have only been here four weeks but the manager has been so helpful and my induction is going really well"; "Management have always been approachable";
"Everyone has been helpful"; "There is always someone on call. Problems are addressed. They have time for you"; "The support is brilliant. The manager has a heart of gold" and "Our views, opinions and concerns are discussed in the staff meetings."

One of the people who lived at the home commented, "I see the managers around most days and if I need to speak to them I will." Another told us, "The carers ask me all the time if everything is OK. Now and again they sit down and talk to me."

A family member told us, "We came in today and the manager came straight over to talk to us and asked if we were happy with everything. The communication is great and she (the manager) is really nice."

When discussing the new medication system, staff were very clear that they had been consulted throughout the decision making process. Staff were also very confident that the registered manager wanted to hear their feedback about the new system and would take it into account. One nurse told us, "We have been asked all along, what we think of it and if we have any problems. Ultimately, if we think it's not right, they (the managers) will definitely go back to the old system."

Records showed that relatives were encouraged to attend a monthly family support group, which was led by the activity co-ordinators and which enabled people to get together and talk about any aspects of the service which they felt could be improved or if they were particularly happy with any areas of good practice. We noted that there was also a suggestion box available in the reception area of the home, so that people could provide anonymous feedback about any aspect of the service, if they so wished. One member of staff told us, "To be honest I am not too sure how often residents' meetings are held, but there is one coming up next week." And another commented, "We have residents' meetings and an advocacy service is available for people who may need it."

A range of staff meetings, for various disciplines were also conducted periodically. This enabled relevant information to be disseminated to the staff team and any topics of interest to be discussed in an open forum. However, one member of staff commented, "The manager is easy to talk to and works very hard, but I

do think we could do with more meetings. The seniors seem to have them, but not the carers." The nursing staff told us meetings were held once a month and were very helpful. They said issues were discussed, such as allocations, particular people with complex conditions and how people needed to be supported.

People we spoke with, who lived at the home and their relatives felt the service was honest, open and transparent. Staff told us they felt the management team were very approachable and we noted a good amount of written guidance was available to support those who worked at Stocks Hall. For example, the employee handbook issued to each new employee contained a wide range of detailed policies, procedures and guidance, such as data protection, confidentiality, codes of conduct, job descriptions, safeguarding adults, discipline and grievance procedures and equal opportunities.

Staff said they were confident in the abilities of the senior nurse and the home manager. They felt they could approach them with concerns and they would take action and support them. They enjoyed working at the home. Staff members we spoke with also felt that communication at Stocks Hall was good and that handovers and a communication book helped them to keep up to date with any changes or new information.

The company had been accredited with some external quality awards, which showed that professional organisations audited the home periodically, to determine if good standards were being maintained. Evidence was also available to demonstrate that the home worked in partnership with other professional organisations. For example, Stocks Hall participated in a trial programme, working with the North West Ambulance Service (NWAS) to monitor and control the need for ambulance requests, using a frail and elderly triage tool. This tool identified between emergency vehicle response, ambulance attendance or further clinical assessment. This helped to reduce the number of hospital attendances and therefore ease the pressure on emergency hospital services. It also enabled those who lived at the home to receive urgent care and treatment from alternative resources, with the possibility of remaining at the home, which also reduced people's anxiety about being taken to hospital by ambulance and therefore promoted good care and support. The registered manager gave us three good examples of when this system was successful. One community professional wrote on their feedback, "One case I was involved in recently was driven by core community services, who needed an appropriate setting for a person, who could have required admission to hospital. The manager at Stocks Hall was involved in all care planning and was supported by the local Community Mental Health Team. This person to date avoided a hospital admission."

A wide range of audits had been conducted, which highlighted any specific aspects of the service needing to be improved or any areas of good practice. These included accidents, care planning, infection control, the environment, health and safety and risk assessing. The results of audits had been analysed regularly. For example, safety incidents had been analysed each quarter. These included areas, such as the circumstances surrounding the incident, any possible contributing factors, the outcome and lessons learnt. Following the analysing process, systems were put in place for updating any relevant records and for implementing a robust action plan, in order to mitigate against the risk of reoccurrence.

Surveys were sent out at regular times of the year and the results of these were routinely analysed. Following this an action plan was developed for any areas showing as in need of improvement, so that any concerns raised could be addressed in a timely manner. A community professional wrote on their feedback, 'The manager is very helpful and supportive.' Another wrote, 'Recently the hospital and community teams struggled placing one person in the local area because numerous homes had said they couldn't manage their needs. The Manager of Stocks Hall was very helpful. She was open to family visiting and when required she completed a timely assessment and provided all the relevant care plans that we asked for. The individual we placed there had a specific risk history and I liked the way that she dealt with this, making staff

fully aware, but not being overt in the manner with which it was discussed. I liked her proactive response to least restrictive practices, whilst maintaining an appropriate risk management plan.'

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take. We did not take formal enforcement action at this stage. We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 11 HSCA RA Regulations 2014 Need for consent We found that consent had not always been obtained from the relevant person prior to care and treatment being provided.